Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Wheelchairs, Durable Medical Equipment, and Supplies

Billing Instructions

Chapter 388-543 WAC

September 2001

About this publication

This publication supersedes all previous MAA Wheelchairs, Durable Medical Equipment, and Supplies Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
September 2001

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I request prior authorization?

All authorization issues, questions or comments should be addressed to:

Write/Call:
Division of Health Services Quality Support
Quality Utilization Section
Durable Medical Equipment
PO Box 45506
(800) 292-8064
(360) 586-5299 (fax)

How do I request a Limitation Extension?

Write/Call:
Division of Health Services Quality Support
Quality Utilization Section
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 (fax)

Where do I address reimbursement issues, questions, or comments?

DME - Program Manager
Professional Rates Section
Division of Operational Support Services
PO Box 45510
Olympia, WA 98504-5510

Where do I call if I have questions regarding Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Important Contacts (cont.)

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

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Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction.

Augmentative Communication Device (ACD) – See "speech generating device (SGD)." [WAC 388-543-1000]

Base Year – The year of the data source used in calculating prices. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.
[WAC 388-543-1000]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies – Supplies that may be used once, or more than once, but are time limited. [WAC 388-543-1000]

Durable Medical Equipment (DME) – Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence.

[WAC 388-543-1000]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.
[WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures.
[WAC 388-543-1000]

Healthy Options – The name of the Washington State, Medical Assistance Administration's managed care program.

House Wheelchair – A nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW. [WAC 388-543-1000]

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000)]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Manual Wheelchair – See "Wheelchair – Manual." [WAC 388-543-1000]

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification card(s) – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Supplies – Supplies that are:

- Primarily and customarily used to service a medical purpose; and
- Generally not useful to a person in the absence of illness or injury. [WAC 388-543-1000]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Supplies that are used only once and then are disposed of. [WAC 388-543-1000]

Other DME – All durable medical equipment, excluding wheelchairs and related items.

Orthotic Device or Orthotic – A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body. [WAC 388-543-1000]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal or Comfort Item – An item or service that primarily serves the comfort or convenience of the client. [WAC 388-543-1000]

Personal Computer – Any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations). [WAC 388-543-1000]

Plan of Care (POC) – (Also known as "plan of treatment" [POT]) A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's residence. [WAC 388-551-2010]

Power-Drive Wheelchair – See "Wheelchair – Power." [WAC 388-543-1000]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts; and
- Provider Enrollment/Relations.

Prosthetic Device or Prosthetic – A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body. [WAC 388-543-1000]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Resource Based Relative Value Scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

Reusable Supplies – Supplies that are to be used more than once. [WAC 388-543-1000]

Revised Code of Washington (RCW) - Washington State laws.

Scooter – A federally-approved, motor-powered vehicle that:

- Has a seat on a long platform;
- Moves on either three or four wheels;
- Is controlled by a steering handle; and
- Can be independently driven by a client.

[WAC 388-543-1000]

Specialty bed – A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay. [WAC 388-543-1000]

Speech generating device (SGD) - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Three- or Four-wheeled Scooter – A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and that has the following minimum features:

- Rear drive;
- A twenty-four volt system;
- Electronic or dynamic braking;
- A high to low speed setting; and
- Tires designed for indoor/outdoor use.

[WAC 388-543-1000]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Trendelenburg Position – A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane. [WAC 388-543-1000]

Usual and Customary Charge – The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

Warranty-wheelchair – A warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase. [WAC 388-543-1000]

Wheelchair-manual – A federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

- Standard:
  - ✓ Usually is not capable of being modified;
  - ✓ Accommodates a person weighing up to two hundred fifty pounds; and
  - ✓ Has a warranty period of at least one year.
- Lightweight:
  - ✓ Composed of lightweight materials;
  - ✓ Capable of being modified;
  - ✓ Accommodates a person weighing up to two hundred fifty pounds; and
  - ✓ Usually has a warranty period of at least three years.
- High strength lightweight:
  - ✓ Is usually made of a composite material;
  - ✓ Is capable of being modified;
  - ✓ Accommodates a person weighing up to two hundred fifty pounds;
  - ✓ Has an extended warranty period of over three years; and
  - ✓ Accommodates the very active person.

- Hemi:
  - ✓ Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet: and
  - ✓ Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.
  - ✓ Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

- Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

- Tilt-in-space: Has a positioning system, that allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

- Heavy Duty:
  - ✓ Specifically manufactured to support a person weighing up to three hundred pounds; or
  - ✓ Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

- Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

- Custom Heavy Duty:
  - ✓ Specifically manufactured to support a person weighing over three hundred pounds; or
  - ✓ Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

- Custom Manufactured Specially Built:
  - ✓ Ordered for a specific client from custom measurements; and
  - ✓ Is assembled primarily at the manufacturer's factory.

[WAC 388-543-1000]

Wheelchair–power – A federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

- Custom power adaptable to:
  - ✓ Alternative driving controls; and
  - ✓ Power recline and tilt-in-space systems.

- Noncustom power: Does not need special positioning or controls and has a standard frame.

- Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[WAC 388-543-1000]

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

About the Program

What is the purpose of the Wheelchairs, Durable Medical Equipment (DME), and Supplies Program?

(Refer to WAC 388-543-1100)

The Medical Assistance Administration's (MAA) Wheelchair Durable Medical Equipment (DME) Program makes accessible to eligible MAA clients the purchase and/or rental of medically necessary DME equipment and supplies when they are not included in other reimbursement methodologies (e.g., inpatient hospital DRG, nursing facility daily rate, HMO, or managed health care programs). The federal government deems DME and related supplies as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the home health program; or
- Required under the early and periodic screening, diagnosis and treatment (EPSDT)/Healthy Kids program.

MAA may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

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Client Eligibility

Who is eligible? **(Refer to Chapter 388-529 WAC)**

Clients presenting Medical Identification cards with the following identifiers* are eligible for wheelchairs, durable medical equipment (DME), and supplies:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program – These clients are dual eligible (Medicare/Medicaid)
CNP **Children's Health**	Categorically Needy Program - Children's Health
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
GA-U **No Out of State Care**	General Assistance - Unemployable
LCP **MNP**	Limited Casualty Program-Medically Needy Program
MNP **QMB**	Medically Needy Program-Qualified Medicare Beneficiaries – These clients are dual eligible (Medicare/Medicaid)

☞ ***Note:** To provide clarification as a result of significant inquiries, clients presenting Medical Identification cards with the following identifiers are not eligible for wheelchairs, DME, and supplies:

- ✓ **QMB-Medicare Only** (Qualified Medicare Beneficiary-Medicare Only)
- ✓ **MIP-EMER Hospital Only – No out-of-state care** (Medically Indigent Program-EMER Hospital Only – No out-of-state care)

Are clients enrolled in managed care eligible?

(Refer to WAC 388-538-060 and 095)

YES! Clients with an identifier in the HMO column on their Medical Identification card are enrolled in one of MAA's Healthy Options managed care plans. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their Medical Identification card.

All medical services covered under a managed health care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider. (WAC 388-543-1400 [9])

Are clients enrolled in Primary Care Case Manager/ Management (PCCM) eligible?

Yes! For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical Identification card for the PCCM. (See the *Billing* section for further information.)

Note: To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtain from the PCCM.

Coverage

What is covered? [Refer to WAC 388-543-1100]

The Medical Assistance Administration (MAA) covers the following subject to the provisions of this billing instruction:

- Wheelchairs and other DME;
- Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
- Orthotic Devices;
- Equipment and supplies for the management of diabetes;
- Replacement batteries (for covered, purchased, medically necessary DME equipment); and
- Bilirubin lights (limited to rentals for at-home newborns with jaundice).

What are the general conditions of coverage?

MAA covers the services listed above when all of the following apply. They must be:

- Medically necessary (see *Definitions* section). The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:
  - ✓ A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or
  - ✓ Video and/or photograph(s) of the client demonstrating the impairments and the client's ability to use the requested equipment, when applicable.
- Within the scope of an eligible client's medical care program (see *Client Eligibility* section);
- Within accepted medical or physical medicine community standards of practice;

- Prior authorized (see *Prior Authorization* section);

- Prescribed by a physician or other licensed practitioner of the healing arts and are within the scope of his or her practice as defined by state law. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity; and

- Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare.

See the *Wheelchair Fee Schedule* and *Other DME Fee Schedule* sections (I and J) for a complete list of covered medical equipment and related supplies, repairs, and labor charges.

Note: The evaluation of a By Report (BR) item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

What are other specific conditions of coverage?

Clients Residing in a Nursing Facility

- MAA covers the following for a client in a nursing facility:

  ✓ The purchase and repair of:

  - A speech generating device (SGD);
  - A wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate; or
  - A specialty bed; and
  - The rental of a specialty bed.

  ✓ All other DME and supplies identified in this billing instruction are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC.

Speech Generating Devices (SGD) [WAC 388-543-2200]

- MAA considers all requests for SGDs on a case-by-case basis.

- The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

- In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment and have one of the following characteristics. For the purposes of these billing instructions, MAA uses the Medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

  - ✓ Digitized speech output, using pre-recorded messages;
  - ✓ Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or
  - ✓ Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

- MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

  - ✓ A detailed description of the client's therapeutic history; including, at a minimum:

    - ➢ The medical diagnosis;
    - ➢ A physiological description of the underlying disorder;
    - ➢ A description of the functional limitations; and
    - ➢ The prognosis for improvement or degeneration.

  - ✓ A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

    - ➢ If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, and an assessment by the prescribing physician, licensed occupational therapist, or physical therapist;

    - ➢ Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;

    - ➢ The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

- An assessment of whether the client's daily communication needs could be met using other natural modes of communication;
- A description of the functional communication goals expected to be achieved, and treatment options;
- Documentation that the client's speaking needs cannot be met using natural communication methods; and
- Documentation that other forms of treatment have been ruled out.

✓ The provider has shown or has demonstrated all of the following:

- The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;
- The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and
- The client's treatment plan includes a training schedule for the selected device.

✓ A prescription for the SGD from the client's treating physician.

- MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.
- **MAA covers SGDs only once every two years for a client who meets the above listed criteria.** MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the above criteria based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

Bathroom/Shower Equipment [WAC 388-543-2300]

- MAA considers a caster-style shower commode chair as the primary option for clients.
- MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:
  - ✓ Is able to propel the equipment; and
  - ✓ Has special positioning needs that cannot be met by a caster-style chair.
- All other circumstances will be considered on a case-by-case basis, based on medical necessity.

Hospital Beds [WAC 388-543-2400]

- Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:
  - ✓ MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary (see EPA criteria for hospital beds, page G.6 and G.7);
  - ✓ MAA determines rental on a month-to-month basis if a client's prognosis is poor;
  - ✓ MAA considers a purchase if the need is for more than six months;
  - ✓ If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.
- MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

- MAA considers a full electric hospital bed only if the client meets all of the following criteria:

  ✓ The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

  ✓ The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

  ✓ The client's medical condition requires immediate position changes;

  ✓ The client is able to operate the controls independently; and

  ✓ The client needs to be in the Trendelenburg position.

- All other circumstances for hospital beds will be considered on a case-by-case basis, based on medical necessity. (See also EPA criteria in Section G.)

What if a service is covered but considered experimental or has restrictions or limitations? [WAC 388-543-1100 (3) and (4)]

- MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.

- MAA evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165 (see page G.3 for limitation extensions).

How can I request that equipment/supplies be added to the "covered" list in this billing instruction? [WAC 388-543-1100 (7)]

An interested party may request MAA to include new equipment/supplies in these billing instructions by sending a written request to MAA's Quality Utilization Section (see *Important Contacts* section*)*, plus all of the following:

- Manufacturer's literature;
- Manufacturer's pricing;
- Clinical research/case studies (including FDA approval, if required); and
- Any additional information the requestor feels is important.

What is not covered? [Refer to WAC 388-543-1300]

MAA pays only for durable medical equipment (DME) and related supplies and services that are medically necessary, listed as covered, meet the definition of DME and medical supplies (see *Definitions* section), and prescribed per the provider requirements in this billing instruction (see *Provider Requirements* section).

MAA considers all requests for covered DME, related supplies and services, and noncovered equipment and related supplies, and services, under the provisions of WAC 388-501-0165 which relate to medical necessity. When MAA considers that a request does not meet the requirements for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

MAA specifically excludes services and equipment in this billing instruction from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- Requested for a child who is eligible for services under the EPSDT program;
- Included as part of a managed care plan service package;
- Included in a waivered program; or
- Part of one of the Medicare programs for qualified Medicare beneficiaries.

Services and equipment that are not covered include, but are not limited to:

- Services, procedures, devices, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) consider investigative or experimental on the date the services are provided;

- Any service specifically excluded by statute;

- More costly services or equipment when MAA determines that less costly, equally effective services or equipment are available;

- A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the Aging and Adult Services Administration (AASA) COPES program for potential coverage);

- Hairpieces or wigs;

- Material or services covered under manufacturer's warranties;

- Procedures, prosthetics, or supplies related to gender dysphoria surgery;
- Shoe lifts less than one inch, arch supports, and nonorthopedic shoes;
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;
- Prosthetic devices dispensed for cosmetic reasons;
- Home improvements and structural modifications, including, but not limited to, the following:

  - ✓ Automatic door openers for the house or garage;
  - ✓ Electrical rewiring for any reason;
  - ✓ Elevator systems, elevators;
  - ✓ Lifts or ramps for the home;
  - ✓ Saunas;
  - ✓ Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;
  - ✓ Swimming pools; and
  - ✓ Whirlpool systems, such as Jacuzzis, hot tubs, or spas.

- Non-medical equipment, supplies, and related services, including but not limited to, the following:

  - ✓ Back-packs, pouches, bags, baskets, or other carrying containers;
  - ✓ Bedboards/conversion kits, and blanket lifters (e.g., for feet);
  - ✓ Car seats for children under five, except for positioning car seats that are prior authorized. Refer to "*Rented DME and Supplies*" for car seats;
  - ✓ Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;
  - ✓ Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;
  - ✓ Electronic communication equipment, installation services, or service rates including, but not limited to, the following:

    - ➢ Devices intended for amplifying voices (e.g., microphones);
    - ➢ Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPES or outpatient hospital programs for emergency response systems and services);
    - ➢ Two-way radios; and
    - ➢ Rental of related equipment or services;

- ✓ Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;
- ✓ Ergonomic equipment;
- ✓ Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, or trampolines;
- ✓ Generators;
- ✓ Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards, etc.);
- ✓ Computer utility bills, telephone bills, Internet service, or technical support for computers or electronic notebooks;
- ✓ Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);
- ✓ Racing stroller/wheelchairs and purely recreational equipment;
- ✓ Room fresheners/deodorizers;
- ✓ Bidet or hygiene systems, paraffin bath units, and shampoo rings;
- ✓ Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;
- ✓ Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or
- ✓ Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

- Personal and comfort items that do not meet the DME definition, including, but not limited to, the following:

  - ✓ Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizers, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;
  - ✓ Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers; and sheets;
  - ✓ Bedside items, such as bed trays, carafes, and over-the-bed tables;
  - ✓ Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;
  - ✓ Clothing protectors and other protective cloth furniture covering;
  - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;
  - ✓ Diverter valves for bathtub;
  - ✓ Eating/feeding utensils;
  - ✓ Emesis basins, enema bags, and diaper wipes;
  - ✓ Health club memberships;
  - ✓ Hot or cold temperature food and drink containers/holders;
  - ✓ Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;
  - ✓ Impotence devices;

- ✓ Insect repellants;
- ✓ Massage equipment;
- ✓ Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See Chapter 388-530 WAC;
- ✓ Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;
- ✓ Page turners;
- ✓ Radios and televisions;
- ✓ Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and
- ✓ Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

- Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

  - ✓ Attendant controls (remote control devices);
  - ✓ Canopies, including those for stroller and other equipment;
  - ✓ Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flap for cars);
  - ✓ Identification devices (such as labels, license plates, name plates);
  - ✓ Lighting systems;
  - ✓ Speed conversion kits;
  - ✓ Tie-down restraints, except where medically necessary for client owned vehicles; and
  - ✓ Warning devices, such as horns and backup signals.

☞ **Note:** MAA evaluates a request for any equipment or devices that are listed as noncovered in this billing instruction under the provisions of WAC 388-501-0165. (Refer to WAC 388-543-1100[2])

Wheelchairs

Wheelchair Coverage **(Refer to WAC 388-543-2000)**

- The Medical Assistance Administration (MAA) bases its decisions regarding requests for wheelchairs on medical necessity and on a case-by-case basis. The following apply when MAA determines that a wheelchair is medically necessary for six months or less:

  - ✓ If the client lives at home, MAA rents a wheelchair for the client; or

  - ✓ If the client lives in a nursing facility, the nursing facility must provide a house wheelchair as part of the per diem rate paid by the Aging and Adult Services Administration (AASA).

- For the purchase of a wheelchair or for wheelchair accessories or modifications for nursing facility clients, MAA requires the provider to complete the Physical/Occupational Therapy Wheelchair Evaluation Form for Nursing Facility Clients (see sample at the end of this section).

• Manual Wheelchairs

MAA considers rental or purchase of a manual wheelchair for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. MAA determines the type of manual wheelchair based on the following:

- ✓ A **standard wheelchair** if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

- ✓ A **standard lightweight** wheelchair if the client's medical condition is such that the client:

  - ➢ Cannot self-propel a standard weight wheelchair; or

  - ➢ Requires custom modifications that cannot be provided on a standard weight wheelchair.

- ✓ A **high-strength lightweight wheelchair** for a client:
  - ➢ Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or
  - ➢ Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.
- ✓ A **heavy duty wheelchair** for a client who requires a specifically manufactured wheelchair designed to:
  - ➢ Support a person weighing up to 300 pounds; or
  - ➢ Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy duty wheelchairs).
- ✓ A **custom heavy duty wheelchair** for a client who requires a specifically manufactured wheelchair designed to:
  - ➢ Support a person weighing over 300 pounds; or
  - ➢ Accommodate a seat width over 22 inches wide.
- ✓ A **rigid wheelchair** for a client:
  - ➢ With a medical condition that involves severe upper extremity weakness;
  - ➢ Who has a high level of activity; and
  - ➢ Who is unable to self-propel any of the above categories of wheelchair.
- ✓ A **custom manufactured wheelchair** for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

• Power-drive Wheelchairs

✓ MAA considers a power-drive wheelchair when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

- ➢ The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category;
- ➢ A power-drive wheelchair will provide the client the only means of independent mobility; and
- ➢ If a child, a power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

✓ All other circumstances will be considered based on medical necessity and on a case-by-case basis. The following additional information is required for a three- or four-wheeled power-drive scooter-cart:

- ➢ The prescribing physician certifies that the client's condition is stable; and
- ➢ The client is unlikely to require a standard power-drive wheelchair within the next two years.

• Coverage of Multiple Wheelchairs

✓ MAA may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

- ➢ The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

- ➢ The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

- ➢ The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, MAA requires the client's situation to meet the following conditions:

  - ◆ The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

  - ◆ Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

  All other circumstances are considered on a case-by-case basis, based on medical necessity.

✓ MAA considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

PHYSICAL/OCCUPATIONAL THERAPY WHEELCHAIR EVALUATION FORM FOR NURSING FACILITY (NF) CLIENTS

Quality Utilization Section (QUS), P.O. Box 45506, Olympia, WA 98504-5506

*Note: the small numbers coordinate with the instructions. **Do NOT alter this form in any way.**

(1) **All spaces MUST be completed by the Physical/Occupational Therapist within 60 days of request**

Client Name: _____ Nursing Facility: _____

Client PIC: _____ (2) RX on File? Yes ☐ No ☐

Therapist Name: _____ Fax Number: _____

(3) Diagnoses/Specific Disabilities as applies to requested equipment including relevant degree of contractures.

(4) Indicate if applicable: Scoliosis _____ Kyphosis _____ Degree of curvature _____

Client height _____Weight _____Lower leg length _____Hip Measurement _____

Upper leg length _____

(5) What is the anticipated length of use of this equipment in ***months and/or years***? _____

Walking Distance **in feet** w/Minimal Assist _____ w/o Assist _____

A) During physical therapy/restorative treatments only? Yes ☐ No ☐

B) Client walking with assistance to NF activities? Yes ☐ No ☐

PLAN OF USE: Full time, exclusive, permanent? Yes ☐ No ☐ **Hours per day _____**

(6) **If manual wheelchair**, can they effectively, **INDEPENDENTLY, WITHOUT CUES**

propel the wheelchair? Yes ☐ No ☐

If YES, **NUMBER OF FEET PROPELLED AT ONE TIME IN REQUESTED WHEELCHAIR:**

_____ With arms ☐ with feet ☐ both ☐

If power wheelchair, can they safely utilize/drive the chair? Yes ☐ No ☐

If YES, **NUMBER OF FEET AT ONE TIME:** _____

continue to PAGE 2

PHYSICAL/OCCUPATIONAL THERAPY WHEELCHAIR EVALUATION FOR NURSING FACILITY CLIENTS

Quality Utilization Section (QUS), P.O. Box 45506, Olympia, WA 98504-5506

Indicate Client Specific Medical Justification for each of the following: (photos are helpful)

(7) Make and Model of Equipment:

(7 A-F) All Accessories and Modifications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WHEELCHAIR DATA:

Does client currently own a wheelchair? No ☐ Yes ☐, Manual ☐ Power ☐

Purchased by & date: Private ☐, _____DSHS ☐, _____ Donated ☐, _____ Approx. age _____

Make _____ Model # _____ Serial # _____

Does client's current wheelchair meet his/her medical needs? Yes ☐ No☐

(8) If current wheelchair doesn't meet the medical need, why not:

_____

_____

_____

_____

_____

_____

_____ _____

(9 & 10) Physical /Occupational Therapist's Signature Date

INSTRUCTIONS for Completing the Physical/Occupational Therapy Wheelchair Evaluation Form

For Nursing Facility Clients

1. All spaces must be completed by the Physical/Occupational Therapist.

2. RX on file means: You must have a physicians prescription in the client's file for any: a) new equipment, or b) new accessories on existing equipment.

3. List only those diagnosis and disabilities that apply to the equipment being requested.

4. The information regarding scoliosis & kyphosis must be completed when a custom back or wheelchair with tilt-in-space or recline feature is being requested.

5. Indicate length of use in months and/or years. General statements, such as *lifetime* and *indefinite* are not acceptable.

6. When indicating how far the client can independently propel the wheelchair, indicate as applies to the equipment being requested.

1. The make/model of wheelchair and each accessory/modification requested must be justified separately. You may use the lines on the physical therapy evaluation form or you may submit an additional attachment listing each item and the medical necessity for it.

   The following information is necessary when justifying the equipment and accessories:

   A. Indicate what other less expensive alternatives have been tried or considered and why they will not meet the client's medical needs.

   B. All justifications must be client specific. General statements as to standards of care or industrial standards for generalized equipment use are not appropriate to justify specific equipment needs.

   C. When requesting a specialized back or a wheelchair with a tilt-in-space or recline feature, indicate the degree of curvature requiring the modification (e.g. scoliosis, kyphosis, or lordosis).

   D. Indicate if the client has excessive extensor tone/muscle spasticity of the trunk/upper body muscles requiring support or impacting the degree of hip flexion/extension.

   E. For specialized cushions, indicate what other cushions have been tried, what the documented outcome was and the length of trial or what other cushions were considered and why they will not meet the client's medical needs. Also document if client has an existing decubitus and, if so, what the stage is. If the client has a history of decubitus, indicate dates, stage, site and, duration.

   F. Indicate if the client has any musculoskeletal conditions, cast or brace that prevents 90-degree flexion of the knee or hip.

8. If client already owns a wheelchair, and a new wheelchair is being requested, indicate the medical reasons the existing wheelchair no longer meets the client's needs. Indicate if it can be repaired or modified to meet the client's needs and if not, why not. If the chair can be repaired or modified to meet the client's needs, the vendor supplying the equipment will need to submit a cost comparison for repairs vs. purchase.

9. The Physical/Occupational Therapist's signature and date goes on this line. MAA **must** receive this form within 60 days from the date placed on this line.

10. Once a therapy evaluation is on file with DSHS for the client, it is valid for 1 year to allow for repairs. A new therapy evaluation will be required after 1 year has lapsed.

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Provider Requirements

Who is eligible for reimbursement by MAA for providing Wheelchairs, DME, and Related Supplies and Services?

(Refer to WAC 388-543-1200)

- MAA requires a provider who supplies DME and related supplies and services to an MAA client to meet all of the following.

  The provider must:

  - ✓ Providers must have a core provider agreement with MAA;
  - ✓ Have the proper business license;
  - ✓ Have appropriately trained qualified staff; and
  - ✓ Be certified, licensed and/or bonded if required, to perform the services billed to MAA.

- MAA may reimburse qualified providers for DME and related supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

  - ✓ DME providers for DME and related repair services;
  - ✓ Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this billing instruction; and
  - ✓ Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's resource based relative value scale (RBRVS) fee schedule.

- MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

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Authorization

What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions are forms of prior authorization.**

Which items and services require prior authorization?
(Refer to WAC 388-543-1600)

MAA bases its determination about which durable medical equipment (DME) and related supplies and services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

MAA requires providers to obtain PA for the following:

- Augmentative communication devices (ACDs);
- Certain By Report (BR) DME and supplies as specified in this billing instruction;
- Blood glucose monitors requiring special features;
- Certain equipment rentals as specified in this billing instruction;
- Decubitus care products and supplies;
- Equipment parts and labor charges for repairs or modifications and related services;
- Orthopedic shoes and selected orthotics;
- Positioning car seats for children under five years of age;
- Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;
- Wheelchair-style shower/commode chairs;
- Other DME not specifically listed in this billing instruction and submitted as a miscellaneous procedure code; and
- Limitation extensions.

MAA requires providers to obtain PA for the following items and services **if the provider fails to meet the expedited prior authorization criteria in this billing instruction** (see "*What is expedited prior authorization?*" in Section G). This includes, but is not limited to, the following:

- Decubitus care mattresses, including flotation or gel mattress;
- Hospital beds;
- Low air loss flotation system;
- Osteogenic stimulator, noninvasive; and
- Transcutaneous electrical nerve stimulators.

General Policies for Prior Authorization **(WAC 388-543-1800)**

- For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

- MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

  - ✓ The manufacturer's name;
  - ✓ The equipment model and serial number;
  - ✓ A detailed description of the item; and
  - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

- MAA authorizes BR items that require PA and are listed in the fee schedule (see Sections I and J) only if medical necessity is established and the provider furnishes all of the following information to MAA:

  - ✓ A detailed description of the item or service to be provided;
  - ✓ The cost or charge for the item;
  - ✓ A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and
  - ✓ A detailed explanation of how the requested item differs from an already existing code description.

- MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for PA and explain the following:

  - ✓ Why the existing equipment no longer meets the client's medical needs; or
  - ✓ Why the existing equipment could not be repaired or modified to meet those medical needs.

- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

- MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

What is a Limitation Extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization.

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. The primary diagnosis code and HCPCS code or state assigned code; and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Write/Call:
Division of Health Services Quality Support
Quality Utilization Section
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 (fax)

What is expedited prior authorization?

The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected durable medical equipment (DME) procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for DME that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits must be the code number of the product and documented medical condition that meets the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** or ***Comments*** field when billing electronically.

Example: The 9-digit EPA number for rental of a semi-electric hospital bed for a client that meets all of the EPA criteria would be **870000725** (870000 = first 6 digits, 725 = product and documented medical condition).

Vendors are reminded that EPA numbers are only for those products listed <u>on the following pages.</u> EPA numbers are not valid for:

- Other DME requiring prior authorization through the DME program;
- Products for which the documented medical condition does not meet <u>all</u> of the specified criteria; or
- Over-limitation requests.

The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code, or a requested rental exceeds the limited rental period indicated. Providers must submit the request in writing to Quality Utilization or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.) (WAC 388-543-1900[3])

Expedited Prior Authorization Guidelines:

A. **Medical Justification (criteria)** - All information must come from the client's prescribing physician or therapist with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).

B. **Documentation** - The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation file for six (6) years. (Refer to WAC 388-543-1900[4])

☞ **Note:** MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100. (WAC 388-543-1900[5])

EPA Criteria Coding List

Code	Criteria	Code	Criteria

RENTAL MANUAL WHEELCHAIRS

Procedure Code: K0001 RR

700 Standard manual wheelchair with all styles of arms, footrest, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Weighs 250 lbs. or less;
2) Requires a wheelchair to participate in normal daily activities;
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: K0003 RR

705 Lightweight Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Weighs 250 lbs. or less;
2) Can self-propel the lightweight wheelchair and is unable to propel a standard weight wheelchair;
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: K0006 RR

710 Heavy-duty Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Weighs over 250 lbs.;
2) Requires a wheelchair to participate in normal daily activities;
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: E1060 RR

715 Fully Reclining Manual Wheelchair with detachable arms, desk or full-length and swing-away or elevating legrests

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Requires a wheelchair to participate in normal daily activities and is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
2) Has a medical condition that does not allow them to sit upright in a standard or lightweight wheelchair (must be documented);
3) Does **not** have a rental hospital bed; and
4) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Please see note on next page.

Code	Criteria	Code	Criteria

Note (For Rental Manual Wheelchairs):

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, the normal prior authorization process is required. At this time, a new authorization number will be assigned.
4) Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file.
5) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the Diagnoses Related Group (DRG) payment.
6) MAA does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.
7) You may bill for only one procedure code, per client, per month.
8) All accessories are included in the reimbursement of the wheelchair rental code. They may not be billed separately.

RENTAL/PURCHASE HOSPITAL BEDS

Procedure Code: E0292 RR & E0310 RR OR E0305 RR

720 Manual Hospital Bed with mattress with or without bed rails

Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or less;
2) Has a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file);
3) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file);
4) Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time he/she is in the bed;
5) Does not have full-time caregivers; and
6) Does **not** also have a rental wheelchair.

Procedure Code: E0294 RR & E0310 RR OR E0305 RR

725 Semi-Electric Hospital Bed with mattress with or without Bed Rails

Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or less;
2) Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file);

Continued on next page.

Code	Criteria	Code	Criteria

3) Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation;
4) Must be able to independently and safely operate the bed controls; and
5) Does **not** have a rental wheelchair.

Note:

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including all of the specified criteria) must be documented in the client's file. Monthly updates from the prescribing physician justifying continued rental, including length of need/life expectancy, must also be included in the client's file.
4) Authorization must be requested for the 12th month of rental at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied.
5) If length of need is greater than 12 months, as stated by the prescribing physician, a prior authorization for purchase must be requested either in writing or via the toll-free line.
6) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the DRG payment.
7) MAA does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.
8) Hospital beds **will not** be provided:
   a. As furniture;
   b. To replace a client-owned waterbed;
   c. For a client who does not own a standard bed with mattress, box spring, and frame; or
   d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom.
9) Only one type of bed rail is allowed with each rental.
10) Mattress may **not** be billed separately.

Procedure Code: E0294 1P

726 Semi-Electric Hospital Bed with mattress with or without bed rails

Initial purchase if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or more;
2) Has tried positioning devices such as: pillows, bolsters, foam wedges, and/or rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file);

Continued on next page.

Code	Criteria	Code	Criteria

3) Has one of the following diagnosis:

   a. Quadriplegia;
   b. Tetraplegia;
   c. Duchenne's M.D.;
   d. ALS;
   e. Ventilator Dependant; or
   f. COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate position change of more than 30 degrees.

4) Must be able to independently and safely operate the bed controls.

Documentation Required:

1) Life expectancy, in months and/or years.
2) Client diagnosis including ICD-9-CM code.
3) Date of delivery and serial #.
4) Written documentation indicating client has not been previously provided a hospital bed, purchase or rental (i.e. written statement from client or caregiver).

☞ **Note:**

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) This EPA criteria is to be used only for an initial purchase per client, per lifetime. It is not to be used for a replacement or if EPA rental has been used within the previous 24 months.
3) It is the vendors' responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental.
4) Hospital beds **will not** be covered:

   a. As furniture;
   b. To replace a client-owned waterbed;
   c. For a client who does not own a standard bed with mattress, box spring and frame; or
   d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom.

LOW AIR LOSS THERAPY SYSTEMS

Procedure Code: 0196E RR

730 Low Air Loss Mattress Overlay

Initial 30-day rental followed by one additional 30-day rental in a 12-month period if **all** of the following criteria are met. The client:

1) Is bed-confined 20 hours per day during rental of therapy system;
2) Has at least one stage 3 decubitus ulcer on trunk of body;
3) Has acceptable turning and repositioning schedule;
4) Has timely labs (every 30 days); and
5) Has appropriate nutritional program to heal ulcers.

Procedure Code: 0931E RR

735 Low Air Loss Mattress without bed frame

Initial 30-day rental followed by an additional 30 days rental in a 12-month period if **all** of the following criteria are met. The client:

1) Is bed-confined 20 hours per day during rental of therapy system;
2) Has multiple stage 3/4 decubitus ulcers or one stage 3/4 with multiple stage 2 decubitus ulcers on trunk of body;
3) Has ulcers on more than one turning side;
4) Has acceptable turning and repositioning schedule;
5) Has timely labs (every 30 days); and
6) Has appropriate nutritional program to heal ulcers.

740 Low Air Loss Mattress without bed frame

Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

Code	Criteria	Code	Criteria

Procedure Code: 0197E RR

750 Air Fluidized Flotation System including bed frame

Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

For All Low Air Loss Therapy Systems

Documentation Required:

1) A "Treatment & Therapy Evaluation Form for Decubitus Care Clients" must be completed for each rental segment and signed and dated by nursing staff in facility or client's home.
2) A new form must be completed for each rental segment.
3) A re-dated prior form will not be accepted.
4) A dated picture must accompany each form. (See sample form on pp. G.13 and G.14.)

Note:

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

NONINVASIVE BONE GROWTH/NERVE STIMULATORS

Procedure Code: E0730 RR

760 Transcutaneous Electrical Nerve Stimulator (TENS)

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Demonstrates a condition that is causing chronic intractable pain, defined as pain that is of long duration that has been difficult to manage;
2) Has a pain level documented at 6 or greater on a scale of one to 10;
3) Has a date of onset at least 6 months ago;
4) Has had no surgery within the previous 3 months;
5) Is receiving continual pain and/or anti-inflammatory medication;
6) Has had at least 5 physical therapy visits during the past 6 months with no perceptible improvement in pain relief or activity level; and
7) Has an objective of decreasing/ discontinuing medications and increasing level of activity.

Procedure Code: E0730 1P

761 Transcutaneous Electrical Nerve Stimulator (TENS)

Purchase unit after 2 months of EPA or prior authorized rental if **all** of the following criteria are met. The client:

1) Is using the unit 6 or more hours per day or 2 or more hours per day for the Alpha Stim brand;
2) Has a pain level documented at 5 or less on a scale of one to 10;
3) Has been a reduction in prescription medication use for chronic intractable pain condition; and
4) Has an increased activity level.

Code	Criteria	Code	Criteria

Procedure Code: E0747 1P

765 Non-Spinal Bone Growth Stimulator

Allowed for purchase when one or more of the following criteria is met. The client:

1) Has a nonunion of a long bone fracture after 6 months have elapsed since the date of injury without healing; or
2) Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.

Procedure Code: E0748 1P

770 Spinal Bone Growth Stimulator

Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when one or more of the following criteria is met. The client:

1) Has a failed spinal fusion where a minimum of 9 months have elapsed since the last surgery; or
2) Is post-op from a multilevel spinal fusion surgery; or
3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

☞ **Note:**

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

MISCELLANEOUS DURABLE MEDICAL EQUIPMENT

Procedure Code: 0170E RR

800 Breast pump, electric

Unit may be rented for the following lengths of time and when the criteria are met. The client:

1) Has a maximum of 2 weeks during any 12-month period for engorged breasts;
2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection;
3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate; or
4) Has a maximum of 2 months during any 12-month period if the client meets **all** of the following:
   a. Has a hospitalized premature newborn;
   b. Has been discharged from the hospital; and
   c. Is taking breast milk to hospital to feed newborn.

Procedure Code: E0935 RR

810 Continuous Passive Motion System (CPM)

Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following:

1) Frozen joints;
2) Intra-articular tibia plateau fracture;
3) Anterior cruciate ligament injury; or
4) Total knee replacement.

Code	Criteria	Code	Criteria

Procedure Code: E0650 RR

820 Extremity pump

Up to 2 months rental during a 12-month period for treatment of severe edema.

Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be:

1) Medically effective;
2) Medically necessary; and
3) A long-term, permanent need.

Note:

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to QUS (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

LOW AIR-LOSS THERAPY SYSTEMS

TREATMENT & THERAPY EVALUATION FORM FOR DECUBITUS CARE CLIENTS

Quality Utilization Section (QUS), P.O. Box 45506, Olympia, WA 98504-5506

ALL spaces MUST be completed by the Nursing Staff

(All information must be current within 30 days of service dates. You must keep appropriate documentation to substantiate this information in your files.)

☞ A current dated photo of the decubitus/decubiti must accompany this form.

Client Name: _____ Client PIC: _____

Facility Name: _____ Phone/Fax# _____/_____

(if applicable)
Rx Physician: _____
Phone/fax# _____/_____

Diagnosis/Specific Disabilities: _____

_____

_____

Prognosis/Life Expectancy _____ Patient Height: _____ Weight: _____ Ideal Body Weight: _____

Rate the following Always, Sometimes, or Never:
Mental/Behavioral: Alert _____ Oriented _____ Compliant with care _____
Comments: _____

_____

Medical Assistance Administration (MAA) policy states: The client's medical condition requires them to be bed confined (20hrs/day) during rental of therapy system.

1) How many hours/day is client in bed? _____
2) How many hours/day is client up in wheelchair? _____

Comments: _____

Wound Evaluation: **(Must be current stage not "healing stage")**

	A.	B.	C.
Location			
Size			
Depth			
Stage			
Tunneling			
Drainage			

Continue to PAGE 2

LOW AIR-LOSS THERAPY SYSTMS
TREATMENT & THERAPY EVALUATION FORM FOR DECUBITUS CARE CLIENTS
Quality Utilization Section (QUS), P.O. Box 45540, Olympia, WA 98504-5540

ALL spaces MUST be completed by the Nursing Staff

(All information must be current within 30 days of service dates. You must keep appropriate documentation to substantiate this information in your files.)
Wound Evaluation (cont):

1) Turning & Repositioning schedule:
_____

2) List all medications_____

_____

_____

3) List all treatments/dressings:_____

_____

Nutritional/Dietary Status:

1) Fluid intake: _____
2) Feeding:

a) Tube fed? Yes ___ No ___ b) Self fed? Yes ___ **No**____ With Assist? Yes ___ No ___

c) Total daily calories? _____ d) # of calories needed for healing _____

e**) List all supplements given** _____

Labs:

Date drawn _____

1) Albumin _____ **2**) Hematocrit _____

3) Hemoglobin _____

Additional Comments: _____

_____

_____

*__If this request is for an extension beyond 3 months rental of therapy system and there has not been a substantial improvement in wound status, please provide an explanation why including what changes in treatment are being implemented to improve healing potential.__

_____

_____

_____

Nursing Staff Signature & Title _____ _____ **Date** _____

Reimbursement

General Reimbursement for DME and Related Supplies and Services **(Refer to WAC 388-543-1400[1-5])**

- MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

  - ✓ The provider meets all of the conditions in WAC 388-502-0100; and

  - ✓ MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

    - ➢ Hospice providers' per diem reimbursement;
    - ➢ Hospital's diagnosis related group (DRG) reimbursement;
    - ➢ Managed care plans' capitation rate; and
    - ➢ Nursing facilities' per diem rate.

- MAA sets maximum allowable fees for DME and related supplies using available published information, such as:

  - ✓ Commercial databases for price comparisons;
  - ✓ Manufacturers' catalogs;
  - ✓ Medicare fee schedules; and
  - ✓ Wholesale prices.

- MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

- MAA updates the maximum allowable fees for DME and supplies no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment at different times during the year.

- A provider must not bill MAA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

What criteria does MAA use to determine whether to purchase or rent DME for clients? **(Refer to WAC 388-543-1100[8])**

MAA bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

MAA purchases or rents medically necessary equipment and supplies only when the item requested is not included in other reimbursement methodologies. Other reimbursement methodologies include, but are not limited to:

- Hospitals' diagnosis-related group (DRG) reimbursement;
- Nursing facilities' per diem rate;
- Hospice providers' per diem reimbursement; or
- Managed care plans' capitation rate.

The amount MAA pays for medically necessary services is the lower of the usual and customary charges or rates established by MAA and:

- The services are within the scope of care in this billing instructions (see *Coverage* section);
- The services are properly authorized;
- The services are properly billed;
- The services are billed in a timely manner as described under WAC 388-502-0150;
- The client is certified as eligible; and
- Third-party payment procedures are followed.

Purchased DME and Related Supplies
(WAC 388-543-1500)

- DME and related supplies purchased by MAA for a client is the client's property. MAA reimbursement for covered DME and related supplies includes all of the following:

  - ✓ Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;

  - ✓ Fitting and set-up; and

  - ✓ Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

- MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

  - ✓ Any DME that MAA considers purchased according to these billing instructions (see "*Rented DME and Supplies"* in section H) requires repair during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

- MAA rescinds purchase orders for the following reasons:

  - ✓ If the equipment was not delivered to the client before the client:

    - ➢ Dies;
    - ➢ Loses medical eligibility;
    - ➢ Becomes covered by a hospice agency; or
    - ➢ Becomes covered by an MAA managed care plan.

  - ✓ A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per the stipulations listed above, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

  - ✓ A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

    - ➢ MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

    - ➢ MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary (see *Definitions* section); then

    - ➢ The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

Rented DME and Related Supplies [WAC 388-543-1700]

- MAA's reimbursement amount for rented DME includes all of the following:

  - ✓ Delivery to the client;
  - ✓ Fitting, set-up, and adjustments;
  - ✓ Maintenance, repair and/or replacement of the equipment; and
  - ✓ Return pickup by the provider.

- MAA requires a dispensing provider to ensure the DME rented to an MAA client is both of the following:

  - ✓ In good working order; and

  - ✓ Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.

- MAA considers rented equipment to be purchased after 12 months' rental unless one of the following apply:

  - ✓ The equipment is restricted as rental only; or
  - ✓ Other MAA published issuances state otherwise.

- MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:

  - ✓ Bilirubin lights for newborns at home with jaundice; and
  - ✓ Electric breast pumps.

- MAA's minimum rental period for covered DME is one day.

- MAA requires that both the begin date and the end date of a rental segment be indicated on the HCFA-1500 claim form in the "dates of service," "from," and "to" areas for all rental billings.

- If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:

  - ✓ MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and

  - ✓ The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.

- MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rental as appropriate.

- For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles for rental equipment when either of the following applies:

  - ✓ The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or

  - ✓ Medicare considers the equipment purchased.

- MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to an MAA client.

When does MAA not reimburse under fee-for-service?

[WAC 388-543-1100 (5)]

MAA does not reimburse for DME and related supplies and repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

- An inpatient hospital client;
- Eligible for both Medicare and Medicaid, and is staying in a nursing facility in lieu of hospitalization;
- Terminally ill and receiving hospice care; or
- Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

DME and Supplies Provided in Physician's Office

MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the Resource Based Relative Value Scale (RBRVS), when it is appropriate.

Warranty

- MAA requires providers to:

  - ✓ Furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties; and
  - ✓ Include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased as provided in this billing instruction (see "*Rented DME and Supplies"* in section H). (Refer to WAC 388-543-1500[3][4])

- MAA charges the dispensing provider 50% of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

  - ✓ Any medical equipment that MAA considers purchased according to this billing instruction (see "*Rented DME and Supplies"* in section H) requires replacement during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

MINIMUM WARRANTY PERIODS	
Wheelchair Frames (Purchased New) and Wheelchair Parts	**Warranty**
Powerdrive *(depending on model)* Ultralight Active Duty Lightweight *(depending on model)* All Others	1 year - lifetime lifetime 5 years - lifetime 1 year
Electrical Components	**Warranty**
All electrical components whether new or replacement parts including batteries	6 months - 1 year
Other DME	**Warranty**
All other DME not specified above (excludes disposable/ non-reusable supplies)	1 year

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

> ☞ **Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance (otherwise known as "dual-eligible"), **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page K.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Note:**

✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.

✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? (Refer to WAC 388-502-0020)

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome;
  - ✓ Specific claims and payments received for services; and
  - ✓ Any specifically required forms for the provision of DME.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tie breaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. Insured's Date of Birth: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. Employer's Name or School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. Insurance Plan Name or Program Name: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. Name of Referring Physician or Other Source: When applicable, enter the referring physician or Primary Care Case Manager name.

17a. I.D. Number of Referring Physician: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. Reserved For Local Use: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here.

21. Diagnosis or Nature of Illness or Injury: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/ dummy diagnosis code such as V58.9.

22. **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Use only one authorization number per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2002 = 110402). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **9**.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) or state-unique procedure code for the services being billed. **MODIFIER:** When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

Sample HCFA-1500 Form

Sample HCFA-1500 Form

Sample HCFA-1500 Form

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid after I've sent them to Medicare?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, "*MA07-The claim information has also been forwarded to Medicaid for review*," it means that your claim has been forwarded to MAA.

Q: What if my claim(s) does not appear on the RA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, "MA07-The claim information has also been forwarded to Medicaid for review, " it means that your claim has been forwarded to MAA.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance Advice and Status Report (RA) within 45 days of the Medicare statement date, you should bill MAA the *paid lines* on the HCFA-1500 claim form **with** an "XO" in box 19.

If **Medicare denies** a service, bill MAA the *denied lines*, using the HCFA-1500 claim form **without** an "XO" on the claim.

REMEMBER! Attach a copy of Medicare's EOMB.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has **paid** or 365 days from date of service if Medicare has **denied**.

Note: Claims billed to MAA with payment by Medicare must be submitted with the same procedure code used to bill Medicare.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 4, 2001 = 090401). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **9**.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required**. Enter the amount you billed Medicare for the service performed.** If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the number of units billed and paid for by Medicare.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

Sample Medicare Part B/Medicaid Crossover Form